

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1649

1. PLACE OF DEATH: 2

(a) County St. Louis

(b) City or town Wellston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
6750 Page Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Ernest Middleton. 343

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Milidge Middleton.

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased February 6, 1897.
(Month) (Day) (Year)

8. AGE: Years 42 Months 7 Days 10 If less than one day hr. _____ min. _____

9. Birthplace Greenville, S. Carolina.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business _____

MOTHER FATHER { 12. Name Dont know.

13. Birthplace Greenville, S. Carolina.
(City, town, or county) (State or foreign country)

14. Maiden name Dont know.

15. Birthplace Greenville, S. Carolina.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mr. Milidge Middleton.

(b) Address 6750 Page Ave.

17. (a) Burial (b) Date thereof 9-18-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch Inc.

(b) Address 5966-68 Easton Ave.

19. (a) SEP 16 1939 (b) R. M. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County St. Louis

(c) City or town Wellston.
(If outside city or town limits, write "RURAL")

(d) Street No. 6750 Page Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16. year 1939. hour About 4 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured aneurysm at junction of Internal carotid and Right middle cerebral arteries.

Due to Congenital

Other conditions Small fracture of the squamous portion of R. Temporal bone.

Major findings: Of operations _____

Of autopsy (see above)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 14

23. Signature John [Signature] (M. D. or other) 1

Address Coroner of St. Louis County Date signed 9/16/39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Leonard W. Kasegus....., Registered Apprentice No.....
working under my personal supervision.

Signed.....*Leonard W. Kasegus*.....

Licensed Embalmer No. *2678*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

2B
21-407
22653

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33567-
Registrar's No. 1649-

Registration District No. Primary Registration District No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town.....
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... years, months or days)

3. (a) PRINT FULL NAME Ernest Middleton

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 9-16-39 (b) J.P. M... M.D. P.C. (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept. 16 day 39- year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....; that I last saw h..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured aneurysm of internal carotid & middle cerebral arteries
Due to Congenital

Due to Small fracture squamous portion of temporal bone

Other conditions (Probably one of a fall in home)
(Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?..... (Specify type of place) (e) Means of injury.....

23. Signature J.P. M... O'Connell (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

